Electronically Delivered

February 22, 2024

Licensee
31521 172nd Street, LLC
31521 172nd Street
Princeton, MN 55371

RE: Project Number(s) SL39205015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on January 31, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00.

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRDAppealsForm**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39205	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
31521 172ND STREET LLC	31521 172ND STREET PRINCETON, MN 55371

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39205015 On January 29, 2024, through January 31, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 5 residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the	0 485		

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0 485	Continued From page 1 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The [licensee's name] Client Agreement, page 2	0 485		

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0 485	Continued From page 2 of 18, section 3, titled Services Included, indicated the licensee offered three meals per day from standard meal plan, and snacks. On page 14 of 18, section 25, titled Additional Information, indicated, "Entering into a Meal/Food plan with [licensee's name] is entirely optional and is not required to become and/or remain a Client at [licensee's name]. You have the option to opt out of meals by providing written notice to [licensee's name]. If you choose to opt out of the included meals, you will be responsible to obtain and prepare your own meals." On January 30, 2024, at 3:42 p.m., registered nurse (RN)-E stated residents were offered three meals daily, per their contract. RN-E stated there was not an option for a resident to opt out of just one meal or two meals, because it was included in the monthly cost whether they chose to eat all three meals or not, and stated, "We have a package. They all get three meals a day. It's a package." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as	0 510		

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0 510	Continued From page 3 applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of two employees (licensed practical nurse (LPN)-F) observed to provide personal cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 30, 2024, at 8:41 a.m., the surveyor observed LPN-F and unlicensed personnel (ULP)-I providing personal cares for R4. LPN-F and ULP-I donned (put on) gloves, and LPN-F used a washcloth to wipe R4's face and hands. LPN-F loosened R4's brief and used disposable wipes to clean R4's pubic area and between the thighs. Without removing the soiled gloves, LPN-F commented that her lanyard/name tag was "in the way" and used her gloved hands to tuck her name tag into the front of her shirt. Without removing the gloves, LPN-F moved to the bottom of the bed, pulled the bed linens out of the way, pulled a clean disposable brief over R4's	0 510		

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0 510	Continued From page 4 ankles, and put on socks. LPN-F walked over to the corner of the room and pulled a mechanical standing lift to the side of R4's bed, touching the handles with the soiled gloves. LPN-F moved the package of disposable wipes out of the way, and stated she was going to get a clean washcloth. Still without removing the soiled gloves, LPN-F opened R4's bottom dresser drawer to grab a washcloth, went into the attached bathroom, and turned on the faucet. LPN-F came out of the bathroom, used the washcloth to wipe R4's abdominal creases and applied powder to the abdominal creases and between the thighs. Without removing the gloves, LPN-F assisted R4 to a sitting position, positioning R4's lower legs over the side of the bed, and positioned the standing lift platform under R4's feet. LPN-F removed R4's pajama top, obtained deodorant from a drawer touching the handle, applied the deodorant, and assisted to put on a sweatshirt. LPN-F placed the sling for the standing lift around R4's upper body, and buckled the sling and leg straps. ULP-I pressed the remote to assist R4 to a standing position and LPN-F used a disposable wipe to clean R4's lower back and buttocks. The incontinence pad on R4's bed was noted to be covered with light yellow urine. R4 was transferred to the toilet, and LPN-F removed the gloves and washed her hands. LPN-F donned clean gloves. R4 announced that she was finished using the toilet. LPN-F used the remote on the standing lift to assist R4 to stand, used a disposable wipe to clean R4's bottom, and without removing the gloves, pulled up R4's brief and pants. LPN-F removed her gloves, and without performing hand hygiene, touched the handles on the standing lift and the joystick on the motorized wheelchair, and transferred R4 into her motorized wheelchair. LPN-F gathered supplies and put them away, and then washed	0 510		

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0 510	Continued From page 5 her hands. During an interview on January 30, 2024, at 12:40 p.m., registered nurse (RN)-E stated gloves should have been removed after wiping soiled areas of the body and hand hygiene should have been performed immediately after removing the gloves and before applying clean gloves. The licensee's Gloves policy, effective April 18, 2023, directed gloves should be removed when there was direct contact between the employee and contaminated objects, and hands should be washed after removing gloves. The licensee's Hand Washing policy, effective April 18, 2023, directed when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing the gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency	0 650		

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0 650	Continued From page 6 evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of four employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a start date of April 22, 2022. ULP-C's record lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs.	0 650		

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0 650	Continued From page 7 On January 31, 2024, at 9:28 a.m., ULP-C stated she had not had a performance review since being evaluated a month after she was hired. On January 31, 2024, at 9:30 a.m., registered nurse (RN)-E stated ULP-C did not have an annual performance evaluation in her record. The licensee's Employee Records policy, dated November 10, 2022, indicated employee records for each person would include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 8 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 29, 2024, at 1:58 p.m., the surveyor observed the facility's Emergency Preparedness Book, last reviewed October 4, 2023, in a white binder located in a hanging organizer on the wall, near the facility's main entrance. The licensee's plan lacked the following required content: - procedure related to sewage/waste disposal; and - EP testing/annual testing requirements.	0 680		

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0 680	Continued From page 9 On January 31, 2024, at 1:25 p.m., assisted living director in residence (ALDIR)-H stated the emergency preparedness plan lacked a procedure related to sewage/waste disposal during an emergency, and there was no documentation of exercises to test the EP at least twice per year, as required. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy, dated April 7, 2023, directed the emergency preparedness plan would include all required elements of Appendix Z, including risk assessment and planning, policies and procedures, communication plan, and staff training and exercises/drills. The policy also included, the licensee would conduct, at a minimum, two (2) emergency preparedness drills every 12 months, and indicated the drills do not include required fire/evacuation drills. One annual exercise would be a full-scale community wide exercise, the second annual exercise would either be a second full-scale community wide exercise or a tabletop exercise focused on the licensee's setting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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0 730	Continued From page 10 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	0 730		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 11 status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's diagnoses included vascular dementia, diabetes, and Asperger's syndrome (autism spectrum disorder affecting social interaction and communication). R3 began receiving services on July 15, 2022, and was discharged on June 30, 2023. R3's progress notes, dated June 23, 2023, indicated R3 was incoherent, had not eaten or drank all shift, and had gurgled respirations with hoarse sounding voice. Staff were directed to call R3's guardian and 911 was called. R3 was transported to the hospital. The progress notes on June 30, 2023, indicated staff spoke with R3's guardian and was informed R3 would not be returning to the facility, and would be admitted to a different facility upon discharge from the hospital.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39205	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
31521 172ND STREET LLC	31521 172ND STREET PRINCETON, MN 55371

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0 730	Continued From page 12 R3's record included a Discharge Summary/Transfer to Another Facility, dated June 30, 2023, which indicated R3's admission and discharge date, supportive services that he received while at the facility, the reason for discharge and the name and location of the facility R3 was being discharged to, R3's condition upon discharge, current equipment used, current physicians, assistance needed with activities of daily living, and R3's pharmacy information. There was no evidence that the discharge summary was provided to the resident, and with the resident's consent, the resident's representatives and case manager. The discharge summary lacked the following: - a summary of the resident's stay that included diagnoses and allergies. On January 30, 2024, at 1:40 p.m., registered nurse (RN)-E stated she wasn't aware that the licensee's discharge summary was lacking the required content. RN-E stated the form was the same for all residents being discharged. The licensee's Resident Discharge Summary policy, undated, indicated the resident's discharge summary should provide a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results. In addition, the policy directed the discharge summary would be provided to the resident, and with the resident's consent, the resident's representatives and case manager. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain a portable fire extinguisher as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 30, 2024, at 9:00 a.m., survey staff toured the facility with maintenance (M)-G. During the tour, survey staff observed monthly inspections were recorded on the back of the	0 790		

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0 790	Continued From page 14 kitchen fire extinguisher tag in November, December, and January 2023. The tag showed annual maintenance was completed in May 2023 by certified service personnel. No monthly inspections were recorded from June to October 2023. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview, M-G verified monthly fire extinguisher inspections had not been completed every month as required. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 15 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 29, 2024, at 1:45 p.m., survey staff toured the facility with clinical nurse supervisor (CNS)-A. During the tour, survey staff observed the following: 1. A space heater was plugged into a power strip in occupied resident bedroom 3. This space heater was sitting on top of a dresser and a notepad was stored directly behind it. Space heaters must not be plugged into power strips, which could overheat and result in a fire. Combustible materials must not be stored in front, behind, or to the side of a space heater when being used. On January 30, 2024, at 9:00 a.m., survey staff toured the facility with maintenance (M)-G. During the facility tour interview, M-G verified the space heater was used improperly. 2. The space heater was on and observed to be hot in occupied resident bedroom 1. This space heater was sitting on a nightstand and the back of the heater was adjacent to the wall. Papers were stored in front of the space heater. The space heater did not have a safety certification label or mark. Proper clearances must be provided around space heaters when being used. On January 30, 2024, at 9:00 a.m., survey staff toured the facility with maintenance (M)-G. During the facility tour interview, M-G verified the space heater lacked a safety certification mark and was	0 800		

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0 800	Continued From page 16 improperly located. 3. A smoking area sign was posted on the back of the building: no receptacle or container was provided in this area for the disposal of pipe ashes or cigarettes. CNS-A stated one resident who smoked used this area to remove ash from the pipe by tapping it on the side of the building. A non-combustible container must be provided for the disposal of pipe ashes and burnt cigarettes in designated smoking areas. On January 30, 2024, at 9:00 a.m., survey staff toured the facility with maintenance (M)-G. During the facility tour, an uncovered bucket with sand in the bottom had been placed on the ground at the back of the building near the smoking area sign. During the facility tour interview, M-G explained the bucket was a temporary solution until an appropriate style of container was purchased for the disposal of cigarettes and pipe ash for this designated smoking area. M-G explained currently there was one resident at the facility who smoked, and they used a pipe. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the	01060		

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01060	Continued From page 17 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a	01060		

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01060	Continued From page 18 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included heart failure, respiratory failure, diabetes, chronic kidney disease, and muscle weakness. R1's progress notes indicated: - October 10, 2023, R1 was found unresponsive at 7:45 a.m., with purple lips and pale skin color. 911 was called. At 8:00 a.m., paramedics arrived and R1's oxygen saturation level dropped to 58%. R1 was transported to the hospital and intubated. R1 was later transferred to another hospital with a collapsed lung and was on a ventilator. Relocation letter was sent. - October 14, 2023, R1 continued to be hospitalized, intubated, and on tube feedings. - October 16, 2023, Ombudsman letter of notification was sent. - December 13, 2023, R1 returned to the facility. R1's Client Service Plan, dated December 13, 2023, indicated R1 received services including medication administration, treatment management, assistance with bathing, hygiene, grooming, dressing, incontinence care, food preparation, behavior management, housekeeping and laundry. The service plan identified R1's brother as his emergency contact. R1's Client Agreement, dated December 13,	01060		

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01060	Continued From page 19 2023, indicated R1 declined to name a designated representative and no legal representative was listed. R1's Notification of Emergency Relocation, undated, indicated the letter was sent to an unidentified female, listed the reason for relocation as condition change, identified R1 was relocated to the hospital and was being transferred to another hospital, included contact information for the Office of Ombudsman for Long-Term Care (OOLTC), identified R1's current length of stay was three days, and included information regarding the right to appeal if the facility refused to provide housing or services after the relocation. On January 30, 2024, at 1:50 p.m., registered nurse (RN)-E stated the name of the addressee on the relocation notice was R1's county case manager. RN-E could not verify if the relocation notice was given to R1, and stated R1 was "his own person" and had no legal or designated representative. R1's record lacked evidence of a written notice provided to the resident that contained, at a minimum: - the contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; and - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. On January 30, 2024, at 1:55 p.m., RN-E stated	01060		

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01060	Continued From page 20 the above contents were not included on the relocation notice and stated she was not aware of the required content. RN-E stated the same relocation notice form was provided for all residents that were relocated due to an emergency. The licensee's Emergency Relocation policy, dated June 6, 2022, noted the licensee could remove a resident from the facility in an emergency if necessary, due to a resident's urgent medical needs. In the event of an emergency relocation, the policy directed the licensee would provide a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal, and will provide contact information for the agency to which the resident may submit an appeal. The policy also included the notice required will be delivered as soon as practicable to: - the resident, legal representative, and designated representative; - the resident's case manager; and - the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. The policy lacked direction to include contact information for the Office of Ombudsman for	01060		

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01060	Continued From page 21 Mental Health and Developmental Disabilities in the written emergency relocation notice, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of four employees (licensed practical nurse (LPN)-B, unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290		

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01290	Continued From page 22 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-B LPN-B obtained her LPN license on September 5, 2006. LPN-B was hired by the licensee on February 24, 2022, to provide direct care services to the residents. LPN-B's employee record contained a background study, submitted by a licensee with a different Health Facility Identification Number (HFID), operated by the same corporation, dated February 24, 2022. LPN-B's employee record lacked evidence the licensee submitted a background study for their license and current HFID number until January 29, 2024, after the survey was initiated. ULP-C ULP-C started employment on April 22, 2022, to provide direct care assisted living services to the licensee's residents. ULP-C's employee record contained a background study, submitted by a licensee with a different HFID, operated by the same corporation, dated April 22, 2022. ULP-C's employee record lacked evidence the licensee submitted a background study for their license and current HFID number until January 29, 2024, after the survey was initiated.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 23 During an interview on January 30, 2024, at 3:18 p.m., assisted living director in residence (ALDIR)-H stated she was made aware that the background studies for LPN-B and ULP-C were submitted with the wrong HFID number and were affiliated with the correct HFID number after learning of this, after the survey was initiated. The licensee's Background Studies policy effective June 7, 2023, directed all employees, contractors and all volunteers of the facility with direct resident contact would undergo a background study through the Department of Human Services (DHS) NETStudy program and once an approved background study had been received, staff would be allowed to interact or provide services to residents, assuming all other requirements had been met. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *01/29/24*
Time: 12:20:43
Report: 1017241018

Food and Beverage Establishment Inspection Report

Location:
Northern Meadows
31521 172nd Street
Princeton, MN55371
Sherburne County, 71

Establishment Info:
ID #: 0042391
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CHEESE LOCATED IN UPRIGHT COOLER
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	0

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, EMPLOYEE ILLNESS LOG, HAND WASHING.

Type: Full
Date: *01/29/24*
Time: 12:20:43
Report: 1017241018
Northern Meadows

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1017241018 of 01/29/24.

Certified Food Protection Manager: NICOLE ALDES

Certification Number: FM 107381 Expires: 06/22/24

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: _____

NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017241018

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/29/24
Time In 12:20:43
Time Out

	Address	City/State	Zip Code	Telephone
Northern Meadows	31521 172nd Street	Princeton, MN	55371	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0042391		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 02/01/24

Inspector (Signature)